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SPECIAL REPORT: Conflct of interest and PSRO

In the best of all imaginable legal worlds, PSROs would be composed of saints who had renounced all ties to the hospitals where they worked and the medical communities from which they drew support. Their judgments would be free from personal bias and unshaped by hidden pressures.

But ours is not the best imaginable legal world. It is inevitable that the actions and decisions of PSRO members and employees will respond, at least in part, to community pressures of various sorts. When the influence is minor, or when it is well-known and unavoidable, the law takes no interest. But when the influence is large, and is hidden -- from the public at large or from other PSRO members who might be affected -- then the law may step in.

A conflict of interest occurs wherever a decision-maker's loyalties are pulled two ways. In the context of PSRO operations, this situation can come up on a number of levels:

THE BOARD OF DIRECTORS

Federal PSRO regulations do not establish any special rules for members of the PSRO's boards of directors. It is probably safe to assume that the normal common-law rules will, therefore, apply. The common-law rule is that a director owes a "duty of ordinary care" to his corporation or organization. He is expected to vote for only the sorts of expenditures that he

Special Report (Continued on pg. 2)

WASHINGTON REPORT

Contracts with private insurers: Solution to PSRO funding bind?

WASHINGTON, D.C.--The Department of Health, Education, and Welfare has come up with a way for planning PSROs to gain conditional status without federal funds -- by contracting with private insurers to review private patients.

It was always intended that PSROs would perform quality assurance and utilization review functions for the private sector, but only after having taken on those tasks for Medicare and Medicaid patients.

Reversing the process, DHEW feels, could solve a great many problems -- including the current fiscal restraints on PSRO development.

SIMMONS: "IT MAKES SENSE"

Deputy Assistant Secretary for Health Henry E. Simmons, M.D., made the suggestion first at the last National Professional Standards Review Council meeting and expanded on it later for PSRO Update.

Aside from the budgetary considerations, he said, the proposal "makes all kinds of sense."

At meetings with DHEW, the Blue Cross Association, Health Insurance Association of America, and American Hospital Association have all gone on record in favor of using PSROs for their own review needs.

"I think that is all to the good," Dr. Simmons said. "We will have an efficient system, under uniform standards -- set by the profession -- working not only for the

Washington Report (Continued on pg. 8)

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would permit if it were his money at stake rather than the corporation's. If a director permits his organization to spend money in a way that no person of reasonable prudence would countenance, and the organization is harmed, the director is personally liable for his share of the damage.

What does this mean for the director of the PSRO? It is his responsibility to spend the government's money in a reasonably prudent way. In a situation in which the PSRO must purchase goods or services from other organizations, it is the director's obvious duty to see that the items purchased are the cheapest available of those of acceptable quality. If one of the suppliers is an organization in which the director has a personal interest, it is his minimum duty to warn his fellow directors explicitly of that interest; in some cases it is appropriate for him to abstain from voting on the matter. It would be highly improper for him to lobby behind the scenes for the PSRO to make any contract which would not be in its best interests.

If the federal government discovers evidence of financial impropriety as a result of a board member's divided loyalty, it will probably use all the administrative and legal resources at its disposal to recover the lost money and remove the director from his position in the PSRO.

THE ADMINISTRATIVE DIRECTOR

The common law looks at a corporation's administrative director (executive officer, president, or whatever he is called) as a servant of the board. Although he is a servant in a legal sense, it must be recognized that a PSRO's administrative director, who has overall day-to-day responsibilities for the smooth functioning of the PSRO, has a position of power and influence. For this reason, as well as OPSR's belief that the operational management of a PSRO is a full-time job, federal guidelines (in Letter of Transmittal #12) now specify that a PSRO will not be able to maintain conditional status -- or become operational -- unless the administrative director works full time for the PSRO.

When the administrative director wears two hats, however, he must be as careful to protect the PSRO's interests as the directors should be. If an administrator's recommendation to the board leads it to act in a way that proves harmful to the PSRO legally or financially, the board may not be able to sue him -- but it can fire him, and probably will.

THE REVIEWING PHYSICIAN

OPSR guidelines provide that no case may be reviewed by a physician who has a personal or monetary interest in it. What constitutes "interest" can be hard to define, however.

Clearly, no PSRO can let a doctor review his own patients. Similarly, when two or more physicians are in a partnership to which they contribute a percentage of their earnings and from which they draw salaries or other compensation, those physicians should not be allowed to review their partners' cases. Owners of a proprietary hospital should not ordinarily be allowed to review the care provided in the institution they own.

Should the prohibitions go further? In a very real sense, every physician has a personal and financial interest in assuring that the hospital in which he practices maintains sound financial status. For political reasons, however, the PSRO law was designed to encourage in-house review unless and until DHEW's data reliably shows such review ineffective. This position reflects the common-law rule that conflict of interest will not be presumed, but must be proven.

THE REVIEW COORDINATOR

Just as the physician reviewer has an interest in maintaining his hospital's solvency, so does the review coordinator who is employed by a fully delegated hospital. Nevertheless, PSRO guidelines take the same position with the coordinator as they do with the physician reviewer: Conflict of interest must be proven and will not be presumed.

CONCLUSION

Current PSRO guidelines on conflict-of-interest situations closely reflect common-law rules. If the guidelines did not exist, and trouble developed, leading to litigation, the courts would probably hammer out similar results. Most important, in either case, is that PSRO members and employees act in the PSRO's best interests at all times, and if such action is not possible, they should remove themselves from the decision-making process until the conflict is removed.

Progress Notes from the Northeast

P/S/R/O Update New England & New York

New York

Most PSROs in the New York area are in a "mark-time" state, awaiting the word from Washington on their conditional applications. Nevertheless, work is continuing on numerous aspects of PSRO organization.

In the NEW YORK COUNTY HEALTH SERVICES ORGANIZATION, work is proceeding on a computerized listing of physician members, with a listing of hospital affiliation, according to Eleanore Rothenberg, deputy executive director. Names of the physicians will be distributed to individual hospitals. The work is under the supervision of Dr. Richard Nolan, chairman of the membership committee, who has worked closely with the Committee of Interns and Residents, an organization working in the New York City area.

In the ADIRONDACK PROFESSIONAL STANDARDS REVIEW ORGANIZATION (Glens Falls), criteria committees are being organized, while the PSRO awaits word from Washington on its application, according to Conrad Kazsmarek, executive director. He reports that some of the 16 hospitals in the area have sent him copies of utilization review plans they have submitted to the state officials.

Meanwhile, the BRONX MEDICAL SERVICES FOUNDATION, INC., has sent letters to 20 hospitals regarding delegation, according to Harry Feder, administrator. "We expect to delegate to most of the hospitals," he said. "The early responses--from six thus far--indicate they all want to have delegated status."

The NEW YORK PSRO STATE-WIDE SUPPORT CENTER, directed by Morton Chalef, has been actively recruiting members for PSROs in AREA 8 (POUGHKEEPSIE), which has some 1,200 physicians. Thus far, more than 250 physicians have signed membership cards. The Center is doing the same thing for SUFFOLK COUNTY, and has received 400 signed cards.

Through clerical errors in Washington, the QUEENS COUNTY PSRO has not been funded. Meanwhile, according to Dr. Lester J. Candela, executive director of the Queens County Medical Society, more than 40 per cent of the physicians in Queens have signed up. Dr. Candela reports that the hospital committee has met with representatives of the hospitals, and that work is continuing, despite the lack of funds.

Physicians on the hospital review committee of the KINGS COUNTY HEALTH CARE REVIEW ORGANIZATION hope to begin visiting the hospitals and watching the UR process, Sheryl Buchholtz, associate director, noted. She said that the Criteria Committee is working on a guide for Brooklyn hospitals, and is developing a suggested workshop for criteria study for nurse-coordinators. Meanwhile, a committee of nurse-coordinators from the hospitals is meeting monthly.

From Syracuse, the PSRO OF CENTRAL NEW YORK, INC., reports that the 11-county area has been divided into four districts, and, should Washington approve, there will be nurse-coordinators in each district. Meanwhile, according to Mary Ann McClanahan, assistant to Stephen K. Leech, project director, committees are starting to contact the 28 hospitals in the area.

From AREA 9 PSRO OF N.Y. STATE, INC., Michael Maffucci, executive director, reports that the PSRO has been meeting with hospital administrators and chiefs of staff of the nine hospitals in the area. He said the PSRO hopes to develop a model plan that can be used by the hospitals in their utilization review development, so that the hospitals can be ready by the July 1 deadline.

"Meanwhile, I understand that Washington wants a few clarifications on points we made in our final proposal," he said.

In the area covered by the NASSAU PHYSICIANS REVIEW ORGANIZATION, all 16 hospitals are working on their UR plans, according to Eugene O'Reilly, project director.

"We have received letters from each of the 16 acute short-stay hospitals requesting UR delegation, and are considering the letters," O'Reilly said. "We have to evaluate each hospital's request and see if it meets the federal guidelines. Then, the only question will be getting the hospitals' mechanisms for reporting the data."

N.Y. PSROs, state agency quarrel over roles in review

Friction has developed in New York state between PSROs and State Health Department officials over hospitalization review committees, a survey by PSRO Update reveals.

On the one hand, PSROs contend that their area of authority is being invaded by state officials. On the other, state officials reply that they are required by law to cover the hospitalization review field. The developing fray has confused many hospitals caught between the two sides and left them wondering who will run the review program.

'VERY TOUCHY PROBLEM'

One PSRO official phrased the situation in these words: "It's a very touchy problem. We don't want to do anything to upset the state people and create all kinds of tension. We are all in the same boat, trying to see if medical care can be improved."

Dr. Roger C. Herdman, deputy commissioner for research and medical care, New York State Health Department, denies that the state group seeks to infringe upon the "prerogatives" of the PSROs.

"The problem, by and large, is that the Health Department has not been relieved of any of its responsibilities under Medicaid," Dr. Herdman told PSRO Update. "We have not been told by Governor Carey, the New York State Legislature or DHEW to discontinue utilization review."

Dr. Herdman insists that all statutes are still in effect. "At present, there is no PSRO beyond the planning stage," he pointed out. "So we are not in a position to discontinue any of our activities."

Dr. Herdman maintains "We still have the responsibility for UR, and we're forced to act in that capacity." He added that there "won't be more than three or four PSROs that will get conditional status" in the immediate future, and thus the state must continue to cover this area.

JULY 1 DEADLINE

"Right now, the PSROs are not sure of the real definition of their roles," Dr. Herdman said. "Our role is pretty well defined. We have to perform our function. The hospitals by July 1 must implement the utilization review regulations of DHEW. We can't be in a position to be wishy-washy about this--we're just going to go ahead."

The state has developed what is called the "NYSHUR" program, a UR program based on federal regulations, according to Dr. Herdman. "We have a computerized data system which collects data on Medicaid discharges from every hospital in the state," he said. "The latest printout brings it to 200,000 cases, and gives us an average for the length of stay."

PSRO officials reply that Section 249-F of Public Law 92-603, which established PSRO, says that PSRO shall do the UR program. As for the "NYSHUR" program, they say it "isn't a system that does anything for the quality of care; it involves the quantity of care--the average number of days of stay."

One PSRO director, Eugene O'Reilly, project director of the Nassau Physicians Review Organization, says Health Department officials are "making specific demands about the setting up of UR committees, and many of the demands go beyond the DHEW guidelines."

PSROs EXCLUDED

He charges that the state "is communicating with the hospitals, and excluding the PSRO from their communication." He says, "We think we have a good chance to implement the DHEW guidelines, and we don't think the state should be so rigid."

Harry Feder, administrator of the Bronx Medical Services Foundation, agrees with O'Reilly. "The state has been asking hospitals to set up UR committees, using NYSHUR standards, which we feel are not correct, since they represent only 28 per cent of Medicaid admissions in the state," he said. "Their length of stay varies from what we've seen. Many of the length-of-stay standards vary from the Professional Activity Study."

Feder also said the state is withholding certain data on the grounds of confidentiality until PSROs become conditional. "By withholding this, the state is holding us back," he added.

Eleanore Rothenberg, deputy executive director of the New York County Health Services Organization, believes the legislation itself leads to some confusion. "The PSRO law collides with the Medicaid utilization review control," she said. While she noted that "we have gone on record that we cannot support the NYSHUR program," she said that her PSRO's relationship with the state officials has been "friendly."

New England

Issues currently important to New England PSROs reflect those of concern nationwide--budgets, data systems, UR regulations, and central control of PSROs. With a total request of between four and five million dollars (compare this to the national PSRO budget of $37 million), nine planning PSROs wait optimistically for Washington to begin on May 1 the public notification process in which dissenting physicians are given the opportunity to object to a PSRO's being designated conditional...Lack of guidance on data systems (along with the issue of reimbursement to hospitals) poses the most serious problem to PSROs at this juncture. And the relief forthcoming in mid-May via a BQA* policy statement will offer the interim solution of sending the conditionals on their own way until July, 1976, when data system models are expected to be fully tested and ready for use by PSROs...The question of making UR regulations compatible with PSRO guidelines has been approached differently throughout Region I; it appears close to resolution in some areas, but the cause of major differences in others. Connecticut and Massachusetts, for example, seem to offer great contrast...As to activities of the PSROs this past month, most of the planning organizations have been working on memoranda of understanding with fiscal intermediaries and the state agencies, and with the individual hospitals that will be seeking delegation for review. The PSROs can, and do, receive technical help for this type of activity from the regional office in Boston, but when it comes to questions of policy, of guidance in ill-defined areas, the PSROs have to look to OPSR in Washington, from which central control of PSROs is maintained.

* * * * *

Massachusetts PSROs, in particular, seem to be involved in a struggle over control of utilization review in hospitals, a knotty problem that draws the Massachusetts Hospital Association into open opposition to Blue Cross. (The problem is closely linked to the issue of foundations for medical care in the state, a topic dealt with in another article in this issue of PSRO Update.)

Essentially, the MHA wants to see review done within the hospitals, and on all patients, while Blue Cross would like a contractual review system for its own beneficiaries.

Closely allied to the question of utilization review is refinement and control of a data system. Two conditionals, BAY STATE in Boston, and CHARLES RIVER in Newton, will begin the operating phase in which they will be testing data systems. Bay State expects to be ready to go to bid sometime in August, and here again, MHA and Blue Cross, among others, would be vying for the contract.

The other three PSROs in Massachusetts are in the planning phase, with two expecting to receive conditional designation by July 1, SOUTHEASTERN MASSACHUSETTS PSRO in Middleboro, and WESTERN MASSACHUSETTS PSRO in Springfield; CENTRAL MASSACHUSETTS HEALTH CARE FOUNDATION in Worcester expects to have its proposal for conditional in by May 26.

The picture in Connecticut shows all four planning PSROs hoping to receive conditional designation July 1, with the notification procedure to begin May 1... In contrast to Massachusetts, endorsement of PSRO-type review of all patients in all hospitals has, for some months, been the philosophical stance of the Connecticut Hospital Association and the Connecticut Medical Institute, as well as the PSROs, but it has yet to be crystallized into policy guidelines for hospitals from the CHA...Continuing to help mesh the new UR regulations for hospitals with PSRO guidelines has kept the individual PSROs busy, while the statewide support center (CMI) has been working on a model of a memorandum of understanding for the PSROs, the fiscal intermediaries and the state agencies. To this end, a statewide meeting hosted by CMI brought together the relevant parties in a working session in mid-April...Through the initiative of two nurse-review coordinators a year ago, Connecticut now has a state association of review coordinators with representatives from every hospital in the state. For the time being, says Myra Psisterer, of EASTERN CONNECTICUT PSRO, INC., they will operate under the umbrella of the CHA.

The status of northern New England PSROs typifies that of most planning PSROs that submitted proposals for conditional March 1 and expect to be designated by July 1. To expedite the process, reports Ronald Thurstan, executive director of PINE TREE PSRO in Maine, Washington arranged a two-hour telephone call in which the application was gone over in detail; from the recommendations made orally, the

*BQA--Bureau of Quality Assurance

PSROs were expected to submit modifications in time to allow the beginning of the notification process May 1. He also notes that his PSRO will conduct a series of four two-and-a-half day workshops for physicians beginning this month at various locations in the state, to familiarize physicians with the concepts and philosophy of PSRO and concurrent review, and to satisfactorily define norms, standards and criteria...

On a slightly different timetable is the VERMONT PSRO, which, after a mid-January submission followed by an official site visit out of Washington, revised and resubmitted the application for conditional in mid-March, according to James A. Gray, M.D., chairman of the board. All hospitals in the state are being reviewed, he said, to see how they are progressing with in-house review; some are ready for delegation of review functions, he notes.

New England PSROs and their ties to FMCs

Prompted by the publicity given a presumed rift in Bay State PSRO and Bay State Foundation in Boston (April PSRO Update), and by queries concerning legalities of these corporate structures, PSRO Update surveyed DHEW Region I (New England) to get a picture of relationships between foundations for medical care and PSROs.

In Massachusetts all five PSROs have foundation ties, while in Connecticut the PSROs are split into two with ties and two without. Rhode Island PSRO started with no foundation impetus; the same is true of Maine. But Vermont had a foundation encompassing a broad array of allied health professionals, a situation which precluded either its converting into a PSRO or its contracting to conduct review functions. (PSROs are limited to medical and osteopathic physicians.) New Hampshire, on the other hand, has a foundation that has been contracted to conduct PSRO review. Two of the Massachusetts PSROs follow this pattern in that they remain foundations whose corporate structures are set up to do PSRO review: Charles River and Central Massachusetts Health Care Foundation in Worcester.

Foundations and medical societies are the logical sources from which the PSROs had been expected to develop; both comprise physician groups concerned with professional standards. When PSROs began forming, they usually became separate from their progenitors by establishing independent boards. In several cases, membership and leadership on these boards overlapped, frequently facilitating the work of peer review that the two usually have in common.

The type of foundation found in the Northeast in most instances is organized not to provide direct medical services to a subscriber group as do many Western foundations.

Instead, the Northeast model is solely a claims-review foundation that provides a service to fiscal intermediaries through its medical expertise in examining claims that fall outside the norms.

In most cases in New England, respondents spoke of the commonness of purpose between PSRO and foundation where the two exist together. If a single executive director wears both a PSRO and a foundation hat, he or she is required by the federal government to be full-time administrator of the PSRO within six months of obtaining conditional status.

ANALYSIS: Confidential data: who owns it, sees it?

BQA's recent Transmittal #16 presents Specifications for Regulations in the area of confidentiality. Medical data and information identifiable to an individual patient, practitioner, institution; deliberations of PSRO reviewers; and information for MCE* studies are all classified as privileged information. Generally, privileged information may be viewed only by the identifiable party and cannot be removed from the PSRO. It is not subject to subpoena in a civil action.

Special procedures are outlined by DHEW for patient access, whereby the attending physician is notified ten days prior to disclosure that he may be present for clarification at the time the patient examines the file. The PSRO should collect only that data necessary for review purposes, and it must make certain that the information it posseses is accurate. Once PSRO (privileged) information has served its purpose, it must be purged from the records.

The question of who owns PSRO data presents a delicate legal problem. It has been argued that ultimate ownership resides in the federal government, but the spirit of the draft regulations and the current development of the program seem to indicate that such records belong to a PSRO organi-

Confidential data (Continued on pg. 8)

*MCE--Medical Care Evaluation

Consumer petition demands public access to PSRO data

A March petition sent by the Massachusetts Consumer Council (MCC) to DHEW requesting disclosure of PSRO data to the public brings up another thorny issue in the development of peer review--whether the public should have access to health-care data.

Because PSROs were formed to monitor care paid for by federally funded health programs, DHEW presently intends to limit access to agencies doing this monitoring. The MCC regards the public as consumers of medical care, who, therefore, should be able to compare the quality and cost of the services they purchase. MCC would have data translated by an intermediary agency into a form usable by the public, keeping only patients' identities secret.

MISINTERPRETATION FEARED

Many physicians fear that lay people will misinterpret and misuse disclosed data. They fear data so simplified that consumers will use improper criteria to determine quality. Length-of-stay statistics, for example, will not in themselves reveal legitimate reasons for longer-than-average hospitalization. The data might also omit factors such as age, general health and multiple problems.

Consumer advocates maintain that the public should have full access to information about services they buy. They charge physicians with imposing self-protective measures on the public's right to know.

"The charge that people will misunderstand or misuse this data is trite," says Paul Gitlin, executive secretary of the MCC. "Physicians are more apt to understand medical procedure, but lay people can understand the relation between cost and service. It's time that doctors lost some of their control over the price of medical care."

A CHECK ON PSROs

Besides, he says, even if the public does not take advantage of the data, its availability serves as a viable check on the functioning of PSROs.

Some PSRO administrative personnel regard the disclosure question as moot because physicians and hospitals can easily withhold damaging information. Physicians delivering legitimate treatment requiring long hospital stays, extensive medication, or large numbers of tests can simply neglect to report the overage in the interest of protecting themselves against computers unable to log data on extenuating circumstances.

"Public disclosure won't be worth much because physicians won't cooperate, and in many cases the data will not be accurate," says Jean Rabinow, an attorney for Boston's University Hospital. "Also, the data is useful to consumers only when it shows extreme deviations from the normal. About 85 per cent of physicians always pass PSRO screening. Of the remaining 15 per cent, most usually exceed the norms for good reason. Only one to two per cent are quacks or overbillers," she said. "PSROs can extract these few from the rest of the 15 per cent only by peer review, not computer checks. So a physician could be materially harmed by disclosure of his PSRO record, but this doesn't mean some of them don't deserve to have the public know about them."

WHO'S TO HAVE ACCESS?

Regulations currently under consideration by DHEW would allow the following personnel access to a record: staff at the hospital of treatment, the insurance company, the state Medicaid funding agency, Medicare carriers, data processing suppliers, computer operators logging the information, the PSRO involved, and any involved PSRO appeals board. Persons concerned about security leaks often do not realize that the first six of these entities already have access to personal records.

Data which does not identify the subject could be made public for the purpose of reviewing aspects of medical care in a general way. This aggregated data could reveal, for example, information about hospitals in a geographical region, or methods of treatment used in specialty practices. The data would be of little use to consumers because it would not identify particular physicians or hospitals.

Though consumers would be unable to use nonaggregated data to choose physicians and hospitals if disclosure is not granted, the information would benefit them indirectly. It would be used on the federal level to weed out unsatisfactory physicians and hospitals. The only time identifying information would be public would be in cases of denied certification for Medicare, Medicaid, or Maternal and Child Care

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Washington Report (Continued from pg. 1)

government but also for the private sector, and in both instances accountable to the public, which ultimately pays the bill."

"It is a very exciting kind of a thing," he said, "and I think it is going to be one of the important things we see in the next couple of years."

DESIGNATION STEPS

The DHEW proposal would work this way: in the absence of federal funding, a planning PSRO, in addition to negotiations with such organizations as state and local health agencies and hospitals, might also negotiate with area health insurers to fill their review needs.

The planning group could still become the designated PSRO for its area and gain conditional status without reviewing federally-funded patients. Review of Medicare and Medicaid patients would be added as federal funds became available.

Dr. Simmons stressed that negotiations would have to be conducted at the area level, although "we are using our good offices here to work out some of the details with the national organizations."

Another major consideration, Dr. Simmons said, is that "it looks from all that is going on that we are going to have a system of national health insurance in which a quality assurance unit will be reviewing all care."

Since the mechanism is already available, "we don't have to wait for national health insurance," he said. "We may as well get started on it now, so that the public can reap the benefits of quality assurance under appropriate standards and with the kind of efficiency that makes the best use of their dollars."

SOME DOING IT ALREADY

"We know it can work," Dr. Simmons said, "because three or four of the 14 conditional PSROs now operating,review private patients in addition to their federal review responsibilities.

"It is a natural marriage of a lot of people's needs."

There was no immediate official reaction from the Council to Dr. Simmons' proposal, but comment from Capitol Hill was generally favorable.

Jay Constantine, professional staff member of the Senate Finance Committee, said there was no legal bar to the DHEW proposal. In fact, he said, the Finance Committee report specifically encouraged the idea of PSROs taking on the review function for private insurers.

"The lower unit costs will certainly help to stretch the federal dollar," he said.

The only reservation, Constantine said, was that the proposal might lead some planning PSROs, "in the beginning, at least," to hurry things along in the interest of getting funding.

Congress, he said, had intended that PSROs should perform the federal function first and then move into the private sector.

PRSO Data (Continued from pg. 7)

benefits.

A possible compromise between DHEW's present policy and MCC demands could be reached by making public data on specific hospitals, but not on specific physicians. Physicians in a badly rated hospital might eventually volunteer disclosure of their records to distinguish themselves from the physicians or administrators they believe responsible for the inferior rating.

Confidential Data (Continued from pg. 6)

zation. Clearly, the responsibility for ensuring the confidentiality of records rests with the individual PSRO.

Employees and officers of a PSRO must sign a special statement and complete a training program concerning their responsibility not to disclose confidential information; individuals who disclose confidential information will be subject to a fine. Each PSRO organization will develop a plan for maintaining confidentiality of records and assign an individual to be responsible for carrying out that plan.

PSRO privileged materials may be disclosed in the appellate and sanctioning procedures for government on-site monitoring and reporting purposes. Only PSRO information that is transmitted to DHEW falls under the federal Freedom of Information Act and is subject to public disclosure.